

# Indiana State Cancer Registry News Briefs



Indiana State  
Department of Health

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## CORRECTION TO NEWS BRIEFS #7 ISSUED DECEMBER 21, 2005

**Casefinding Source** will **NOT** be required for cases diagnosed 1/1/06 and later, contrary to what was announced in NB #7. The CDC/NPCR deferred implementation of the requirement to provide time for a workgroup to improve the codes and instructions for collection. Change reporting status for this field from "Required" to "Not Required" for cases diagnosed in 2006, as this data item is not required by any standard setter. In the NAACCR Standards for Cancer Registries, Volume II, Version 11, this appears as Item #501 in the Required Status Table, Revised November 2005. We apologize for any inconvenience this incorrect information may have caused your registry.

**Primary Payer at Diagnosis** is still "Required When Available" for cases diagnosed 1/1/06 and later (no change).

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### NEW & REVISED DATA ITEMS FOR 2006 CASES

- **RX SUMM** – Systemic/Surgery Sequence (NAACCR Item #1639)  
This is a new data item that must be collected for cases diagnosed 1/1/06 and later. See Attachment A for coding rules.
- **Type of Reporting Source** (NAACCR Item #500)  
Two new codes have been added to this data item in NAACCR Version 11 for 2006 cases. Several additional changes were made in the definitions of codes. Please read the revised codes and definitions closely, as facilities previously defined under code 1 have been split between codes 1, 2, and 8. Please use Attachment B to replace page 39 in your State Hospital Policy and Procedure Manual (Draft 2003) for cases diagnosed 1/1/06 and later.

#### New Codes for Type of Reporting Source

- 2 Radiation Treatment Centers or Medical Oncology Centers (hospital affiliated or independent)
- 8 Other hospital outpatient units/surgery centers

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## WELCOME NEW STAFF MEMBER

The Indiana State Cancer Registry (ISCR) is pleased to announce they have filled the position for a cancer registrar after a two-year search. Janet (Jan) Stengel, RHIA, CTR started working in the ISCR on February 27, 2006, after having spent the past nine years as a cancer registrar at Clarian/IU Hospital in Indianapolis. In her spare time, Jan is an instructor at the Indiana University Health Information Administration program, teaching senior college students about cancer registry functions. She also helped develop the Cancer Registrar Certification Program in the School of Informatics at IUPUI and serves on the National Cancer Registrars Association Informatics Task Force.

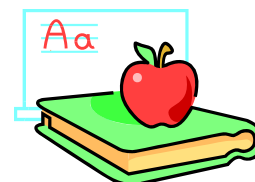
Jan's extensive experience in a hospital registry will provide a solid background for working with hospitals at the central registry, where she will be performing detailed quality control reviews of incoming data from reporting facilities throughout the state. We also look forward to using Jan's teaching skills in future educational workshops sponsored by ISCR and ICRA.

Jan's education includes a Bachelor of Science degree in Health Information Administration from Indiana University, a Bachelor of Arts degree in psychology and physiology from IU, and two years of graduate courses in pharmacology and physiology from Rutgers University in New Jersey. You can reach her at (317) 233-7723 or [jstengel@isdh.in.gov](mailto:jstengel@isdh.in.gov). Welcome, Jan!

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## FUNDAMENTALS OF ABSTRACTING WORKSHOP FOR NEW CANCER REGISTRARS

WHEN: May 6 - 8, 2006  
WHERE: Washington, DC-area; held concurrently with  
NCRA's Annual Conference  
INFO: <http://www.ncra-usa.org/conference/program.htm>



For the first time, NCRA is offering a workshop designed to focus on the concepts of quality abstracting and data reporting practices for cancer registry employees with less than two years experience.

This intensive three-day training program provides an in-depth discussion of the coding rules and reporting requirements and includes several site-specific discussions. In addition, there will be hands-on training exercises incorporated throughout the workshop with designated time for individualized instruction. This program emphasizes the proper use of the coding and reference manuals and techniques to promote quality cancer data.

As an added benefit, attendees will have the opportunity to network with fellow registrars and experience the excitement of the NCRA conference by attending special functions such as the Welcome Breakfast, Opening of the Exhibit Hall, Awards Ceremony, Business Meeting, and much more. This session is a basic session and does not offer CE credits.

## CODING QUESTIONS & ANSWERS

### ***Histology***

Q1. Histology: What is the difference between "papillary carcinoma, NOS," 8050; and "papillary adenocarcinoma, NOS," 8260. They both refer to "papillary carcinoma" (see page 75 of ICD-O-3).

A1. Use 8050 for papillary carcinomas that have no further specification as to cell type (e.g., squamous, 8052; adeno, 8260; transitional, 8130, etc.). If there is further specification, use the appropriate, more specific code. Use code 8260 [Papillary adenocarcinoma, NOS] for Papillary carcinoma of thyroid and Papillary renal cell carcinoma. Histology code 8050 [Papillary carcinoma, NOS] does not include papillary carcinoma of thyroid or papillary renal cell carcinoma.

Reference: ICD-O-3; pgs 75, 185 – From SEER Inquiry System

### ***Size***

Q2. I have a bladder tumor treated with TURBT. The pathologist notes the tumor size to be aggregated, approximately 1.2 cm x 1.0.4 cm. Do I use this size or code to 999?

A2. Code 999. The registrar may not add pieces or chips together to make a whole (FORDS, page 100.) However, the surgeon and the pathologist may "re-assemble" the tumor size and record this aggregate size in the pathology report. The AJCC 6th edition, page 5, column 2, first bullet, states the pathologist may make an effort to reasonably reconstruct the tumor to the approximate native size. The rules for reporting tumor size in FORDS are consistent with those in ROADS. The registrar should report only the largest dimension or diameter of the excised or resected tumor as it is recorded by the pathologist.

Reference: CoC/ACoS Inquiry & Response System #8469

### ***Collaborative Staging***

Q3. For Collaborative Staging (CS), does the registrar use only our facility medical record, or can we also use information from other facilities involved in the case, such as outside path reports, operative reports, H&P, and scans?

A3. Information to accurately stage can be obtained from other facilities involved in the case, in the same manner that was allowed using Summary Stage 2000 (and/or SEER Extent of Disease) prior to January 1, 2004.

Reference: CoC/ACoS Inquiry & Response System #12632

Q4. Are CS fields for non-analytic cases completed by entering 9's?

A4. For nonanalytic cases you should complete CS fields using the codes for unknown or not applicable from the appropriate site-specific scheme. For unknown primary, lymphoma, and leukemia, some of the CS items are coded with 8's (not applicable) and 9's would not be valid codes.

Reference: CoC/ACoS Inquiry & Response System #17420 which corrected #13644.

### ***Melanomas***

Q5. If a melanoma was diagnosed in a staff physician's office, the pathology read at our hospital, and a re-excision done at our facility with the pathology negative, do we pick up the case?

A5. Yes, the original diagnosis was made in the staff physician's office, which is an extension of your facility. If the re-excision intent was to ensure negative margins, you would accession this case.

Reference: CoC/ACoS Inquiry & Response System #9411

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## CODING QUESTIONS & ANSWERS (cont'd)

- Q6. If a cancer registry identifies through a path report a melanoma diagnosed and treated in the staff physician's office, the patient never enters the hospital, but the path lab of the reporting facility reads the specimen, is it Class 7 or Class 6? Is the medical staff status the distinguishing factor?
- A6. If the patient was treated at the hospital, you would pick up the case; otherwise, this would be considered a Pathology consult. This issue is addressed in FORDS as a class of case 7, pathology consult only, and would not be reportable, according to CoC/ACoS reportability rules. HOWEVER, this case IS reportable as a class of case 7 to the Indiana State Cancer Registry in order to ensure all cancer incidence cases are reported.
- Reference: CoC/ACoS Inquiry & Response System #8027 (modified by ISCR)

### **Reportability**

- Q7. Is a staff physician hired by the hospital? Is a physician who has privileges to perform services at the hospital a staff physician?
- A7. A clear and practical definition of the staff physician must be made at each institution. You might want to contact your Medical Staff Office for further clarification.
- Reference: CoC/ACoS Inquiry & Response System #10129
- Q8. If a physician who is hospital staff opened an outpatient med onc office, does the hospital's registry report the cases? If he leaves the hospital system and is on his own, what then? If a staff physician relocates her office to the hospital's medical office building and she is not affiliated with our outpatient medical oncology dept., do we report the cases? If the hospital opens a freestanding out patient radiation center off-site, do we report the cases?
- A8. If the facility owns the services and medical record, the cancer registry is required to abstract these cases. If the facility does not own the services and medical record, this would be a contractual issue between your facility and the off-site services.
- Reference: CoC/ACoS Inquiry & Response System #12407
- Q9. A patient was sent to our facility for a chest x-ray by a referring physician on staff here but not owned by us. The radiologist read the CXR as "findings positive for a malignant process." Is the patient included in our registry? Does it require a staging form and if so, who is responsible to complete the staging form?
- A9. If your facility utilizes radiology for a casefinding source, this case should be included. If included in the cancer registry database, it must be staged. The cancer committee determines a clear and practical definition of the managing physician at each institution.
- Reference: CoC/ACoS Inquiry & Response System #11843

### **HIPAA**

- Q10. With the HIPAA regulations, are VA hospitals treated differently? We requested follow-up information from a VA hospital and they declined to release information without patient authorization. What ruling addresses this, as our state does not require follow-up information?
- A10. VA hospitals are not treated differently. A covered entity may disclose protected health information (without patient consent) to another covered entity for health care operation activities (such as follow-up information). Please refer to our web site <http://www.facs.org/dept/cancer/cannews.html>. There are HIPPA questions and answers available pertaining to follow-up. Scroll down to HIPAA, click on HIPAA: The Business Associate Agreement and FAQs.
- Reference: CoC/ACoS Inquiry & Response System #8266

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Q11. To be in compliance with HIPPA, will our institution need to mail thousands of letters requesting permission for follow up? Or, is follow-up covered under research?

A11 Under the HIPAA Final Privacy Rule, private practice physicians may disclose patient protected health information (PHI) to the hospital for purposes of treatment, payment, and health care operations. The reason we ask for follow-up is to improve quality of care, one of the health care operations sanctioned by the regulations. Please check with the HIPAA compliance officer at your facility for further information about the legislation in your state.

Reference: CoC/ACoS Inquiry & Response System #7892

## **SITE-SPECIFIC COMPARISON OF SUMMARY STAGE 1977 AND SUMMARY STAGE 2000 CODING**

The link below will take you to a new report, Site-specific Comparison of Summary Stage 1977 and Summary Stage 2000 Coding. This report was completed by members of the Collaborative Research Work Group.

[http://www.naaccr.org/index.asp?Col\\_SectionKey=11&Col\\_ContentID=397](http://www.naaccr.org/index.asp?Col_SectionKey=11&Col_ContentID=397)

## **SEER\*RX DRUG DATABASE SOFTWARE AVAILABLE**

From April Fritz, RHIT, CTR to NAACCR on July 1, 2005: The SEER Program is pleased to announce the availability of SEER\*Rx, the cancer registrar's interactive antineoplastic drug database on July 1, 2005. This downloadable database replaces SEER Self-instructional Manual Book 8, Antineoplastic Drugs, effective for cases diagnosed January 1, 2005 and after.

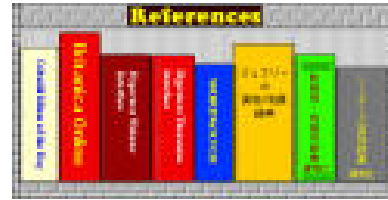
There is NO CHARGE for this program. SEER\*Rx can be downloaded from <http://www.seer.cancer.gov/seerrx>. Registration of your e-mail address, name and institution is necessary in order to obtain the password required to download the program to the desktop of your computer. Once you download and install the program on your computer, you do not have to connect to the Internet to use it. The information you supply will be used for no other purpose than to maintain an e-mail list that will notify you of updates to the database or changes to the software, which will be approximately every six months.

SEER\*Rx allows you to look up the treatment category for over 1600 drugs and the individual treatment categories for the drugs in over 700 regimens. The screen provides information on generic name, brand name, NSC number, drug category and subcategory, cancer sites where the drug is used, and other details, including whether or not the drug should be coded as treatment. As noted, this program replaces the printed Book 8 (published in 1993) and the update to Book 8 issued in May 2002. The categories for a few drugs have changed, notably some monoclonal antibodies such as Avastin, Velcade, Rituxan, Herceptin, and a few others that have been determined to be cytostatic chemotherapy agents rather than traditional immunotherapy. Recoding of these agents for cases diagnosed prior to 2005 is not required or recommended.

## REFERENCES

Hospital & Other Health Care Facilities Directory Resources:  
<http://www.inhha.org/hospitaldir.asp>

<http://www.in.gov/isdh/regsvcs/providers/directories.htm>



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## 2002 & 2003 ANNUAL REPORTS



The 2002 annual report is posted on the ISDH Web site at

<http://www.in.gov/isdh/dataandstats/cancerinc/2002/index.htm>.

There is also a “mini” preliminary annual report available in PDF format for cases diagnosed in 2003. The full 2003 annual report should be posted on the ISDH Web site in Spring 2006. If you want a copy of the “mini” report for 2003 e-mailed to you before then, please contact Lisa Witherite at [lwitheri@isdh.in.gov](mailto:lwitheri@isdh.in.gov) or (317) 233-7111.

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## CONTINUING EDUCATION HOURS FOR SPRING EDUCATIONAL WORKSHOP

The ISCR workshop on Collaborative Staging held in Indianapolis on March 18, 2005 was approved in advance by the Commission on Cancer for 4 hours of Continuing Education (CE) hours. Anita Butz’ afternoon presentation on Palliative Care and Class of Case Issues is also valid for 0.5 hours of CE, although the hours were not prior-approved by NCRA due to an oversight of the State Cancer Registry. The NCRA CE handbook states, “In calculating CE hours, the credit will be awarded to the completed half-hour: (4.25 = 4.0, 4.5 = 4.5, 4.75 = 4.5).



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## ATTACHMENT A

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**SYSTEMIC/SURGERY SEQUENCE****TREATMENT SUMMARY – SYSTEMIC/SURGERY SEQUENCE****RX SUMM – SYSTEMIC SUR SEQ**

Length:	1
Data Type:	Numeric
ACoS:	Required
State Registry:	Required in 2006
Item #:	1639

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**Description**

Records the sequencing of systemic therapy (RX Summ-Chemo [1390], RX Summ-Hormone [1400], and RX Summ-Transplnt/ Endocr [3250]) and surgical procedures given as part of the first course of treatment.

**Rationale**

The sequence of systemic therapy and surgical procedures given as part of the first course of treatment cannot always be determined using the date on which each modality was started or performed. This data item can be used to more precisely evaluate the time of delivery of treatment to the patient.

**Codes**

- 0 No systemic therapy and/or surgical procedures
- 2 Systemic therapy before surgery
- 3 Systemic therapy after surgery
- 4 Systemic therapy both before and after surgery
- 5 Intraoperative systemic therapy
- 6 Intraoperative systemic therapy with other therapy administered before or after surgery
- 9 Sequence unknown

## ATTACHMENT B

<b>TYPE OF REPORTING SOURCE</b>	Length:	1
	Data Type:	Numeric
	ACoS:	N/A
	State Registry:	Required; revised in 2006
	Item#:	500

### Description

This is a required 1-character field for recording the source documents used to abstract the majority of information on the tumor being reported. This may not be the source of original case finding (for example, if a case is identified through a pathology laboratory report review and all source documents used to abstract the case are from the physician's office, code this item 4).

### Rationale

The code in this field can be used to explain why information may be incomplete on a tumor. For example, death certificate only cases have unknown values for many data items, so one may want to exclude them from some analyses. The field also is used to monitor the success of non-hospital case reporting and follow-back mechanisms. All population-based registries should have some death certificate-only cases where no hospital admission was involved, but too high a percentage can imply both shortcomings in casefinding and that follow-back to uncover missed hospital reports was not complete.

### Codes (*effective for cases diagnosed 1/1/06 and later*)

- 1 Hospital inpatient; managed health plans with comprehensive, unified medical records
- 2 Radiation Treatment Centers or Medical Oncology Centers (hospital-affiliated or independent)
- 3 Laboratory only (hospital-affiliated or independent)
- 4 Physician's office/private medical practitioner (LMD)
- 5 Nursing/convalescent home/hospice
- 6 Autopsy only
- 7 Death certificate only
- 8 Other hospital outpatient units/surgery centers

### Notes:

Code in the following priority order: 1, 2, 8, 4, 3, 5, 6, 7. This is a change to reflect the addition of codes 2 and 8 and to prioritize laboratory reports over nursing home reports. The source facilities included in the previous code 1 (hospital inpatient and outpatient) are split between codes 1, 2, and 8.

This data item is intended to indicate the completeness of information available to the abstractor.

### Definitions

- a. **Code 1** has been split into codes 1, 2, and 8, with new definitions. Reports from health plans (e.g., Kaiser, Veterans Administration, military facilities) in which all diagnostic and treatment information is maintained centrally and is available to the abstractor are expected to be at least as complete as reports for hospital inpatients, which is why these sources are grouped with inpatients and given the code with the highest priority.
- b. **Code 2** sources usually have complete information on the cancer diagnosis, staging, and treatment.
- c. **Code 3** is generally for use by independent pathology laboratories. If a hospital's pathology department has a report on a non-hospital case (with no inpatient or outpatient record) and no other information is available, code 3 should be used. For example, a hospital that finds a reportable case by reviewing pathology reports should report the case as Reporting Source 3 if no other records or information were available. This might happen if an outside physician contracted to use the hospital's pathology laboratory facilities.
- d. **Code 4** includes physician offices as well as independent, free-standing clinics with no hospital affiliation. Examples of these may include surgery centers, radiation oncology clinics, and HMOs.
- e. **Codes 6 and 7** are used only when investigation can find no clinical diagnosis of any kind while the patient was alive.
- f. **Code 8** sources would include, but would not be limited to, outpatient surgery and nuclear medicine services. A physician's office that calls itself a surgery center should be coded as a physician's office. Surgery centers are equipped and staffed to perform surgical procedures under general anesthesia. If a physician's office calls itself a surgery center, but cannot perform surgical procedures under general anesthesia, code as a physician office.